Linkage

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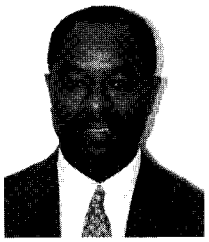
FROM THE OFFICE OF THE DIRECTOR

Maryland's Public Mental Health System in the New Millennium

By Oscar Morgan



The Mental Hygiene Administration, The Maryland Department of Health and Mental Hygiene

Parris N. Glendening, Governor

Georges C. Benjamin, MD Secretary, Department of Health and Mental Hygiene

The Millennium, a span of one thousand years has come to pass, and with that much can be said, much can be learned, and much can be anticipated. Within these time frames we have had the privilege to experience many advances in technology, education and health care. We, as a Nation, can rest assured that no less will emerge in the 21st Century.

The American Heritage Dictionary describes a millennium as "a hoped-for period of joy, serenity, prosperity and justice." Perhaps, the 21st Century will provide for a "hoped-for period" for ending the stigma associated with mental illness. Perhaps it will bring new "prosperity and social justice" for consumers of mental health services. Perhaps, it will mark numerous medical and scientific advances of such magnitude that a full recovery for individuals with brain disorders is not only less traumatic, but readily guaranteed. If we remain focused and dedicated, perhaps all that is envisioned for the 21st Century could be within grasp.

More specifically, what can one expect of Maryland's Public Mental Health System today and throughout the 21st Century? The Mental Hygiene Administration desires that the Millennium be a new beginning towards greater expansion of consumer-choice in both treatment and recovery. Continuing our commitment to instilling fundamental changes in the public's understanding of mental illness, and assuring best practices in the mental health service delivery system, Maryland's Public Mental Health System embraces the New Millennium as an opportunity for optimism. We envision Maryland's Public Mental Health System as a national model in the 21st Century and into the next. Maryland's Public Mental Health System, therefore, engages to advance its consumer-driven system by further expanding consumer choice, and a culturally diverse service array, while refining its operational policies, procedures and regulations to promote recovery of individuals with psychiatric illnesses.

We go forth into the 21st Century with tremendous encouragement by what has been accomplished and all that may be accomplished with the continued support and collaboration of consumers, family members, providers, administrators, and policymakers alike. Jointly, as we continue to refine our public mental health system, the journey towards "what's conceived will be achieved" certainly remains within our grasp.

Looking Forward While Remembering the Past....
a history of public mental health services in Maryland

by Jean Smith

Entering into the 21st Century, we pause; if only briefly to reflect on where we've been and where we're heading as a mental health system. We've come a long way in terms of quality health care, but the road to quality does not end at the doors of the 21st Century. Rather, it opens up greater possibilities for enhanced treatment modalities based on innovative science and communication technologies.

With the dawning of each decade over the past years, we heralded what was thought to be the best mental health treatments. However, in retrospect, some previous "innovations" were not necessarily conducive to what we now call treatment in the least restrictive environment. Therefore, whatever "best practices" now emerge, we need to preserve the rights and dignity of individuals with mental illness, and ensure consumers and families have a voice in policy and in treatment.

Maryland's current Public Mental Health System (PMHS) is continually refining itself to ensure quality and remain "consumer-oriented." However, just a few centuries ago, our system fell far short of this concept compared with the quality and continuum of services that is prevalent today.

In brief, early in the 18th Century mental health services began to experience a shift in treatment philosophy from that of discipline and restraint to "moral treatment." Unfortunately, the philosophy was more in theory than in reality, as history later proved. In that spirit, however, the Public Hospital of Baltimore was established in the late 1700's and eventually became Spring Grove Hospital, the second oldest public hospital in the United States.

In the late 1800's Springfield Hospital opened, and a Commission was established to inspect public and private institutions, and advise a board of managers of their concerns or issues related to services for individuals with mental illness.

In the first decade of the 1900's occupational therapy became a major mode of treatment. Patients in the State psychiatric hospitals began to work at hospital farms. In the early 1900's Crownsville Hospital in Anne Arundel County opened as the State Psychiatric hospital for African-Americans. Followed by the opening of the Eastern Shore Hospital on the Choptank River. In 1922 the Board of Mental Hygiene was established and replaced the aforementioned Commission. In the early 1930's insulin, shock treatments, and lobotomies were introduced as treatment methods for individuals with mental illness. Overcrowding conditions at the hospitals coupled with staff shortages caused a consistent decline in quality conditions. Particularly between 1918-1941 conditions at the hospitals were on such a steady decline that patients were seemingly neglected. In 1949 a series of newspaper articles, "Maryland's Shame," reported on the lack of treatment, overcrowding conditions, lack of heat, and poor quality of food within the confides of these facilities.

In 1949 the Department of Mental Hygiene was created and became responsible for the care and treatment of individuals with mental illness. Census at the State psychiatric hospitals peaked at 9,000 by 1955. In 1963 the Federal Community Mental Health Centers Act passed, emphasizing the development of small community mental health centers (CMHCs). The CMHCs became the hub for community-based treatment, particularly for individuals who were being discharged from State psychiatric facilities. Thereafter, between 1958 and 1982, nine other State psychiatric facilities opened, including a research center, relieving much of the overcrowding conditions. (RICA-Baltimore in 1958, Clifton T. Perkins in 1959, Walter P. Carter Center 1967, Maryland Psychiatric Research Center 1968, RICA-Cheltenham 1976, Thomas B. Finan Center in 1978, Highland health in 1979, RICA-Rockville in 1980 and Upper Shore Community Mental Health Center in 1982). In 1969 the Department of Mental Hygiene reorganized and subsequently became the Mental Hygiene Administration (MHA). With some advances in treatment modalities and additional facilities, census dropped to 7,000 by 1970. By 1975 patient census dropped to approximately 4,600.

In 1976 the Maryland Advisory Council on Mental Hygiene was created, which was later expanded in 1989 to comply with the composition requirements of the federal law PL 99-660 and PL 102-321. The Council was to advise MHA on the provision of services to individuals with mental illness and to be a "strong advocate of a comprehensive, broad-based approach to social, economic, and medical problems." The Council, currently named the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council or the Joint

Council, continues to assist MHA in enhancing Maryland's PMHS.

In 1978 MHA began developing community rehabilitation programs to teach daily living, social, and prevocational skills.

In 1982 the General Assembly passed House Bill 402, which set the stage for the State to significantly expand the community mental health system. Subsequent years echoed with the era of Maryland's "deinstitutionalization movement."

In 1992, the Joint Chairmen of the Maryland General Assembly recommended that an appropriate group be constituted to explore whether future consolidation of Maryland's State psychiatric hospitals was feasible. Thus, a Task Force was formed that began meeting in 1993, with the end result of a final report of their recommendations made available by January 1995 entitled, "Report of the Task Force on Feasibility of Future Consolidation of State Psychiatric Hospitals." In brief, the report recommended the continuing downsizing of all State psychiatric facilities as appropriate with funding redirected for community enhancements; thus, encouraging treatment for individuals with mental illness in the least restrictive environment.

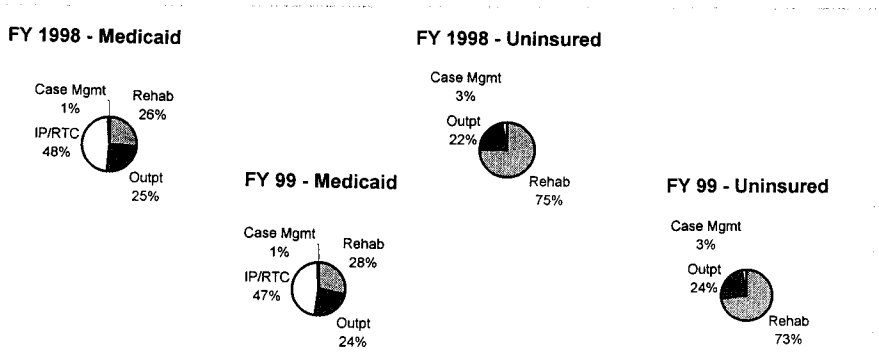
In 1994 MHA reorganized its administrative structure, emphasizing the "consumer as the center" of Maryland's mental health system. In turn, five Assistant Directorates focusing on distinct populations were established (children and adolescents, adults, elderly, forensic, and specific populations.) The restructuring allowed for improved coordination and monitoring of statewide services, and enhanced technical assistance regarding clinical issues and service planning. In that year, the Office of Consumer Affairs was developed as the focal point for consumer input into policy development at the State level, and as a liaison with consumers and advocacy groups.

MHA also began to transition from a central to a more local system of care with the establishment of local mental health authorities (Core Service Agencies) throughout the counties to assist in planning and coordination of services. This refinement of the MHA's operating structure allowed for the closure of Regional Offices (formally established in 1975) in June of 1997. In July of 1997 funding for public mental health services changed from a grant-system to a fee-for-service system; allowing for a one-tiered system of care governed by a uniform medical necessity standards. Hence, furthering the objective of accessibility and flexibility in services, and accountability throughout the system. MHA in 1997 contracted with an administrative service agency, Maryland Health Partners, to help administer the redesigned public mental health system. Finally in May of 1998, MHA implemented a new organizational structure which further improved customer service, streamlined lines of communications, and ensured accountability fiscally, clinically and programmatically.

Fortunately, over time with such continued systems refinements, treatment services for individuals with mental illnesses greatly improved.

The 21st Century rings in with a continued commitment to partner with consumers, providers, and family members to further refine Maryland's Public Mental Health System. MHA remains diligent in the creation and management of a coordinated, comprehensive, accessible, culturally sensitive, and age-appropriate system of services and supports, which provide treatment and rehabilitation in order to promote resiliency, health, and recovery.

Following are statistical analysis of Maryland's current Public Mental Health System and a recapulation of current identified gaps in service.



Maryland's PMHS Consumer Breakdown by Age Group

Fiscal year	*Age Group*	*TOTAL*	*Fiscal year*	*Age Group*	*TOTAL*
1998	GER	6,142	1999	GER	4,882
	CHILD	19,162		CHILD	19,293
	ADULT	45,090		ADULT	47,338
	ADOL	9,618		ADOL	10,261
	Totals:	**80,012**		**Totals:**	**81,774**

Note: Above counts may duplicate for consumers who span age or population groups.

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MARK YOUR CALENDARS

March 10, 2000 10:00 AM to 3:00 PM – **DHMH Annual Spring Fest** focus on ***WOMEN'S HEALTH ISSUES*** at 201 W. Preston Street, Lobby Level; free workshops, health screenings and light entertainment; for more information call (410) 767-6629.

March 10, 2000 -- **"Aging In Place" Conference** at the Maritime Institute; for more information contact Marge Mulcare at (410) 767-1359.

March 17, 2000 – **MHA's Cultural Fest** at the Maritime Institute in Linthicum Heights; for details call Iris Reeves at (410) 767-6616.

March 22, 2000 – **Case Management Conference** at the Meeting House in Columbia; for more information contact Linda Levene at (410) 767-6868.

March 25, 2000 8:00 AM to 4:00 PM – **"Connecting With Kids - Making it Work."** a Workshop. For more information call Howard Held at (410) 876-4800.

April 9, 2000 – Kick-off event at Port Discovery for **"Month of the Young Child"**, for details call OCY&F at (410) 767-4182.

April 3-7, 200 – **DHMH Celebrates Public Health Week**; kick-off event to be held on April 3rd at 11 a.m. at 201 W. Preston lobby area; watch your e-mail for details.

April 9 –11, 2000 – **Maryland Aging Network Workshop 2000** at the Sheraton Fontainebleau Hotel in Ocean City; for more information contact the Baltimore County Department of Aging in Towson, or your local office.

April 13, 2000 – **"Tuerk Conference on Addictions"**, sponsored by the University of Maryland. For more information contact David Lower at (410) 328-0408.

April 14, 2000 – **Tele-Conference on Hate Crimes**; co-sponsored by MHA and Harvard Universities at 201 W. Preston Street in Room L-3; for more information call Henry Westray at (410) 767-5650.

April 19-20, 2000 – **10th Annual HIV/Behavioral Health Sympsoium.** For Information call Nancy McCaslin at 410 679-5480.

MHA Starting Child Respite Care Programs

The Mental Hygiene Administration is in the process of awarding grants to start child and adolescent respite care programs. Seven core service agencies were selected in a recent competitive proposal review process. The Maryland Coalition of Families for Children's Mental Health played a key role in reviewing the initial Request for Expressions of Interest, prior to its release, as well as in the final review of the applications. A total of 15 jurisdictions will have access to the seven new programs. Final budget negotiations are currently underway with the seven applicants and an announcement is imminent. The FY2001 budget contains funds to annualize these programs and possibly start new ones, subject to legislative approval. A statewide training and evaluation activity is also planned.

VIDEOS AVAILABLE:

"Medicare and Mental Health: Benefits, Limitations and Consequences" available for $10.00.

"Hepatitis and Mental Health: Prevention and Treatment' available for $15.00.

To request, call Eileen Hansen, at (410) 706-4967.

Workgroup Favors Advance Directives

By Larry Fitch

Concerns about the ability of mental health systems to serve the needs of people with serious mental disorders have been fueled in recent years by a few highly publicized accounts of violent acts committed by individuals reported to be mentally ill. Public perception is that individuals with mental illness pose a significant risk to public safety. Recent studies, however, demonstrate that the individuals who are mentally ill as a group are no more violent than the rest of society. This fact, however, in no way diminishes the importance of having comprehensive mental health services in place for people with a mental illness.

Even in a system that offers accessible services and promotes choice, some individuals who might benefit from treatment will opt not to be served. To address this issue, in April 1999 the Joint Chairmen of the Senate Budget and Taxation Committee and the

House Appropriations Committee of the Maryland General Assembly directed the Mental Hygiene Administration and the Office of the Attorney General to study the "feasibility and advisability of a pilot project for involuntary outpatient civil commitment or any other measures as determined appropriate" to promote consumer participation in community-based mental health services. A workgroup was established in September 1999 to explore this issue. The workgroup consisted of representatives from the Maryland Legislature, the Attorney General's Office, MHA, Baltimore City's Core Service Agency, the Maryland Disability Law Center, public and private general and psychiatric hospitals, mental health advocacy and support service groups, and members of the judiciary.

After much discussion and examination of laws in other states, review of professional literature, and hearing testimony from three national experts, the workgroup concluded that outpatient civil commitment would not be advisable at this time, and recommended the implementation of advance directives for mental health care (ADMHs) by individuals receiving mental health services in Maryland.

In contrast to outpatient civil commitment (which tends to put consumer and provider as adversaries), advance directives by design promote consumer participation (and cooperation) in planning for treatment. Moreover, while researchers question the efficacy of outpatient commitment, advance directives for mental health care have received very favorable review in recent years.

An advance directive (aka "durable power of attorney," "health care proxy," and "living will") is a legal instrument that an individual may execute to establish his or her wishes for treatment should he or she become incompetent or otherwise unable to make those wishes known at some time in the future. The advance directive may present detailed instructions regarding care to be given should certain circumstances arise (e.g. a mental health crisis), or it may designate another person — an agent or "proxy" — to make treatment decisions on the individual's behalf, consistent with the individual's expressed preferences.

Advance directives, of course, may be used to specify not only treatment to be provided, but also treatment to be withheld. It should not be possible, however, for an individual to forbid his or her subsequent involuntary psychiatric hospitalization. If a competent individual may be committed over objection (as he or she may be under Maryland law), it would make no sense to preclude the commitment of an incompetent individual simply because he or she voiced an objection when competent. The same would be true of involuntary medication of a committed patient, under Maryland law.

Advance directives have been praised as a tool for promoting consumer participation in mental health treatment. In the interest of continuing to promote consumer participation in the initial services, MHA will pursue the establishment of a directive program consistent with guidance provided by the Office of the Attorney General.

Serious Mental Illness and Hepatitis Infection

Researchers at the University of Maryland School of Medicine have discovered that patients diagnosed with serious mental illness (SMI) are much more likely to become infected with hepatitis than others.

The 18-month nationwide study involved nearly one thousand individuals with serious mental illness, including 140 people who were being treated for schizophrenia by the University of Maryland. Among those individuals, the prevalence of Hepatitis B was 23.4 percent (5 times the national average), and the prevalence of Hepatitis C was 19.9 percent (11 times the national average). Most of the patients with mental illness and their doctors were unaware of their hepatitis status.

Hepatitis is an inflammation of the liver that can be caused by a viral or bacterial infection, drug or alcohol abuse, or an immune system disease. There are many types of hepatitis, but Hepatitis B and Hepatitis C are the most serious, and the greatest threat to public health. Both are caused by viruses, which are easily transmitted in the blood or through sexual contact. Blood screening has virtually eliminated the chance of developing hepatitis through a transfusion. But intravenous drug users and those who engage in "unsafe sex" are at extremely high risk for infection. No vaccine exists for Hepatitis C, which is primarily transmitted in blood. But there is a vaccine available for Hepatitis B, which is usually contracted through unprotected sex. Results of the study suggest that doctors should consider recommending the vaccine for mentally ill patients who may be engaged in those high risk behaviors.

Mental Health: A Report of the Surgeon General is available through the Website *www.surgeongeneral.gov.*

In memory of John L. Gildner, Chief Executive Officer of RICA Rocvkille, who passed away on November 3, 1999... the Mental Hygiene Administration would like to acknowledge his immense dedication, leadership and friendship. He inspired many through his devotion to RICA, and his willing spirit to make a difference in the life of a child. He will truly be missed.

Note from Editor: Deadline for submission of articles for next issue of ***Linkage*** is **March 20th, 2000.**

The **2nd Annual DHMH Talent/ Gong Show Winners** were:

FIRST PLACE
Jerry Plummer (IRMA)
SECOND PLACE
Deloris McKoy (ADA)
THIRD PLACE TIE
Roland Knox (W.P.C.C.)
Juanita Sutton
BEST GONG
Calvin Hamilton, Jr.

MPRC/Novartis $24 Million Research Initiative on Schizophrenia

University of Maryland at Baltimore (UMB) recently received $24 million over six years from the Swiss pharmaceutical firm Novartis Pharma AG to discover new treatments for schizophrenia. Schizophrenia affects up to one percent of the world's population, including about 2.7 million Americans. This collaboration brings together one of the country's leading academic research centers in schizophrenia, the Maryland Psychiatric Research Center (MPRC), and one of the world's largest pharmaceutical companies. The partnership will initiate important basic research at MPRC.

One area of focus for the research will be finding ways to treat schizophrenia patients who have "negative" symptoms. Patients with negative symptoms are limited in the experience and expression of emotion, have reduced drive and motivation, and function poorly in occupational and social opportunities. There are no effective drug treatments for these symptoms. Psychiatry is much further advanced in treating "positive" or psychotic symptoms, which include delusions (false beliefs), hallucinations (hearing voices, seeing false images), and disorganization of thinking. This agreement will provide the resources to gain a better understanding of the disease and go on to develop and test new approaches.

The Motor Disorders Clinic of the Maryland Psychiatric Research Center is offering **free screenings for tardive dyskinesia** during early 2000. Referring clinicians will receive a written evaluation; call (410) 402-6820 or (410) 402-6823 for appointments.

Linkage

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Contributions are welcome, but subject to editorial change. Please send to Editor at above address.

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